

FILED DEC 17 1945

Registration District No. **567**

Primary Registration District No. **6076**

Registrar's No. **2700**

1. PLACE OF DEATH:
 (a) County St Louis
 (b) City or town Koch
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: Robert Koch
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 86 mths 19 days
(Specify whether years, months or days)
 In this community 7 yrs

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County - Gas
 (c) City or town St Louis 17
(If outside city or town limits, write "RURAL")
 (d) Street No. 20 S. 22nd St 9
(If rural, give location)
 (e) Citizen of foreign country? na (Yes or No) 1
 If yes, name country -

3. (a) PRINT FULL NAME: Joseph Jackson
 3. (b) If veteran, name war -
 3. (c) Social Security No. no

4. Sex m 2 5. Color or race n
 6. (a) Single, widowed, married, divorced Single
 6. (b) Name of husband or wife -
 6. (c) Age of husband or wife if alive - years
 7. Birth date of deceased 4 8 15
(Month) (Day) (Year)

8. AGE: Years 30 Months 7 Days 18
 If less than one day hr. min.

9. Birthplace Married Miss 1
(City, town, or county) (State or foreign country)

10. Usual occupation W.P.A. worker

11. Industry or business -

MOTHER FATHER
 { 12. Name Harry Jackson
 { 13. Birthplace ? ? a
(City, town, or county) (State or foreign country)
 { 14. Maiden name Martha Hayes 1
 { 15. Birthplace ? ? n
(City, town, or county) (State or foreign country)

16. (a) Informant Hospital Record

(b) Address Robert Koch Hosp. Koch, Mo.

17. (a) (Burial, cremation, or removal) - (b) Date thereof -
(Month) (Day) (Year)

(c) Place: burial or cremation Sept 1945

18. (a) Signature of funeral director Fred Smith

(b) Address 1217 Madison St. St Louis

19. (a) 11-29-45 (b) 68 M. Garman
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 26
 year 45 hour 1 minute 6 P.M.

21. I hereby certify that I attended the deceased from 9
7 1938 to 11-26-45 1945
 that I last saw h. l. m. alive on 11-26-45 1945
 and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis 7 1/2 yrs
 Duration

Due to 13 1/2
 Due to -

Other conditions -
(Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: -
 Of operations -
 Of autopsy -
 Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) -
 (b) Date of occurrence -
 (c) Where did injury occur? -
(City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? -

While at work? - (Specify type of place)
 (e) Means of injury -

23. Signature Bernard Friedman (M. D. or other) M.D.
 Address Robert Koch Hosp. Koch, Mo. Date signed 11-27-45

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.